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Eligible providers and provider types.

- (A) Services may only be provided by the nursing facility (NF), intermediate care facility for the mentally retarded (ICF-MR), or another institution which is certified by the Ohio department of health (ODH) and which has a provider agreement with the Ohio department of jobs and family services (ODJFS).
- (B) The types of certified facilities which may participate in the medicaid program are:
- (1) General nursing facilities (NFs); and
 - (2) Intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD); and
 - (3) Medicare skilled nursing facilities (SNFs); and
 - (4) Medicare skilled nursing and nursing facilities (SNFs/NFs).
- (C) All beds, in a participating facility, except those beds added between July 1, 1987 and July 1, 1993, must be surveyed to determine compliance with the applicable certification standards and, if certifiable, included in the provider agreement under one of the certification categories listed in paragraph (B) of this rule. Certification of noncompliance by ODH is the only basis for a nonparticipating area (distinct part) of a facility.
- (1) Participating facilities may request certification as NFs. All beds which meet NF standards shall be certified as meeting NF standards. Once beds are added to the NF provider agreement, those certified beds may not be removed unless the facility withdraws completely from the medical assistance program. NF beds added between July 1, 1987 and July 1, 1993, may be surveyed for compliance at the discretion of the provider.
 - (2) Participating facilities may request certification as ICFs-MR/DD. All beds which meet ICF-MR/DD standards shall be certified as meeting ICF-MR/DD standards.
 - (3) Participating facilities may request certification as a SNF or SNF-NF. If such beds do not meet the standards for SNF care but do meet the standards for NF care, they shall be certified as meeting the standards for NF care.
 - (4) Participating facilities shall have all medicare skilled nursing beds certified under medicaid and included in the medicaid provider agreement.

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- (D) Distinct parts of a facility may be designated at different certification levels as long as the distinct part designation is approved in writing by ODH.

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Effective: 07/01/2003

R.C. 119.032 review dates: 04/15/2003 and 07/01/2008

CERTIFIED ELECTRONICALLY

Certification

06/20/2003

Date

Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.01, 5111.02, 5111.27,
5111.29
Prior Effective Dates: 4/7/77, 7/1/80, 8/1/82,
1/30/85 (Emer.), 6/1/85,
9/30/87 (Emer.), 9/30/93
(Emer.), 1/1/94, 7/1/00

TN #03-013 APPROVAL DATE MAY 03 2004
SUPERSEDES
TN #20-210 EFFECTIVE DATE 07/01/03

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Provider agreements: nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR).

In addition to provisions in rules 5101:3-3-02.1 and 5101:3-3-02.2 of the Administrative Code, execution and maintenance of a provider agreement between the Ohio department of job and family services (ODJFS) and the operator of a NF or ICF-MR is also contingent upon compliance with requirements set forth in this rule.

(A) Definitions.

- (1) "Closure" means the discontinuance of the use of the building or part of the building that houses the facility as a NF or ICF-MR, that results in the relocation of the facility's residents.
 - (a) A facility's closure occurs regardless of whether there is a replacement of the facility, whereby the operator completely or partially replaces the facility's physical plant through the construction of a new physical plant or the transfer of the facility's license from one physical plant location to another.
 - (b) Facility closure also occurs regardless of whether residents of the closing facility elect to be relocated to the operator's replacement facility or to another NF or ICF-MR.
 - (c) A facility closure also occurs regardless of action taken by the department of health related to the facility's certification under Title XIX of the Social Security Act, 79 stat. 286 (1965), 42 U.S.C.A. 1396, ~~as amended~~(as amended through April 15, 2003), that may result in the transfer of part of the facility's survey findings to a replacement facility, or related to retention of a license as a NF under Chapter 3721. of the Revised Code or as a residential facility under Chapter 5123. of the Revised Code.
 - (d) The last effective date of the provider agreement of a closed facility will be the date of the relocation of the last resident.
- (2) "Continuing care" refers to the living setting which provides the individual with an apartment or lodging; meals; maintenance services; and when necessary, nursing home care. All services are provided on the premises of the continuing care community. The individual signs a contract which identifies the continuum of services to be covered by the individual's initial entrance fee and subsequent monthly charges. If a continuing care contract provides for a living arrangement which specifically states that all health care services including nursing home services are met in full, medicaid payment cannot be

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made for those services covered by the contract. If a continuing care contract provides for only a portion of the resident's health care services, that portion shall be deducted from the actual cost of nursing home care and medicaid shall recognize the difference up to the medicaid maximum per diem. An individual may be eligible for medicaid after a continuing care contract was signed under the conditions in rule 5101:1-39-46 of the Administrative Code.

- (3) "Failure to pay" means that an individual has a medicaid application in pending status and has failed, after reasonable and appropriate notice, to pay or to have the medicare or medicaid program pay on the individual's behalf, for the care provided by the NF or ICF-MR. An individual shall be considered to have failed to have the individual's care paid for if the individual has applied for medicaid, if both of the following are the case:
- (a) The individual's application, or a substantially similar previous application, has been denied by the county department of job and family services (CDJFS); and
 - (b) If the individual appealed the denial pursuant to division (C) of section 5101.35 of the Revised Code, and the director of ODJFS upheld the denial.
- (4) "Medicaid eligible" means an individual has been determined eligible and has been issued an effective date of health care which covers the time period in question by the CDJFS under Chapter 5101:1-39 of the Administrative Code.
- (5) "Operator" means the individual, partnership, association, trust, corporation, or other legal entity that operates a NF or ICF-MR.
- (6) "Voluntary withdrawal" means that the operator of a NF, in compliance with section 1919(c)(2)(F) of the Social Security Act (as amended through April 15, 2003), voluntarily elects to withdraw from participation in the medicaid program but chooses to continue providing services of the type provided by NFs. For ICFs-MR "voluntary withdrawal" means the operator elects to voluntarily terminate from the medicaid program.

(B) A provider of a NF or ICF-MR shall:

- (1) Execute the provider agreement in the format provided by ODJFS; and
- (2) Apply for and maintain a valid license to operate if required by ~~legal~~ philosophy law; and

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- (3) Comply with all applicable federal, state, and local laws and rules; and
- (4) Keep records and file reports as required in rule 5101:3-3-20 of the Administrative Code; and
- (5) Open all records relating to the costs of its services for inspection and audit by ODJFS and otherwise comply with rule 5101:3-3-20 of the Administrative Code; and
- (6) Supply to ODJFS such information as the department requires concerning NF or ICF-MR services to individuals who are medicaid eligible or who have applied to be medicaid recipients.
- (7) Unless the conditions described in paragraph (J) of this rule are applicable, retain as a resident in the NF or ICF-MR any individual who is medicaid eligible, becomes medicaid eligible, or applies for medicaid eligibility. Residents in the NF or ICF-MR who are medicaid eligible, become medicaid eligible, or apply for medicaid eligibility, are considered residents in the NF or ICF-MR during any absence for which bed-hold days are reimbursed in accordance with rules 5101:3-3-59 and 5101:3-3-92 of the Administrative Code.
- (8) Unless the conditions described in paragraph (J) of this rule are applicable, admit as a resident in the NF or ICF-MR, an individual who is medicaid eligible, whose application for medicaid is pending, or who is eligible for both medicare and medicaid, and whose level of care determination is appropriate for the admitting facility. This applies only if less than eighty per cent of the total residents in the NF or ICF-MR are recipients of medicaid.
 - (a) In order to comply with these provisions, the NF or ICF-MR admission policy shall be designed to admit individuals sequentially based on the following:
 - (i) The requested admission date; and
 - (ii) The date and time of receipt of the request; and
 - (iii) The availability of the level of care or range of services necessary to meet the needs of the applicants; and
 - (iv) Gender: sharing a room with a resident of the same sex (except

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married couples who agree to share the same room.)

(b) The NF or ICF-MR shall maintain a written list of all requests for each admission. The list shall include the name of the potential resident; date and time the request was received; the requested admission date; and the reason for denial if not admitted. This list shall be made available upon request to the staff of ODJFS, CDJFS, and the Ohio department of health (ODH).

(c) The following are exceptions to paragraph (B)(8) of this rule:

(i) Bed-hold days are exhausted.

Medicaid eligible residents of NFs who are on hospital stays; visiting with family and friends; or participating in therapeutic programs; and have exhausted coverage for bed-hold days under rule 5101:3-3-59 of the Administrative Code, must be readmitted to the first available semi-private bed in accordance with the provisions of rule 5101:3-3-59 of the Administrative Code; or

(ii) Facility is a county home.

Any county home organized under Chapter 5155. of the Revised Code may admit individuals exclusively from the county in which the county home is located; or

(iii) Facility has a religious sponsor.

Any religious or denominational NF or ICF-MR that is operated, supervised, or controlled by a religious organization may give preference to persons of the same religion or denomination; or

(iv) NF has continuing care contracts.

A NF may give preference to persons with whom it has contracted to provide continuing care.

(v) Prolonged "medicaid pending" application status.

A NF or ICF-MR may decline to admit a medicaid applicant if that facility has a resident whose application was pending upon admission and has been pending for more than sixty days, as verified by the CDJFS. The NF or ICF-MR shall submit the

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necessary documentation in a timely manner as required in rules 5101:3-3-15.1 and 5101:3-3-15.3 of the Administrative Code.

- (9) Effective July 1, 1997 and thereafter, provide the following necessary information to ODJFS and CDJFS to process records for payment and adjustment:
- (a) Submit the "facility/CDJFS transmittal" (JFS 09401) to the CDJFS to inform the CDJFS of any information regarding a specific resident for maintenance of current and accurate payment records at the CDJFS and the facility; and
 - (b) Submit the "facility payment and adjustment authorization" (JFS 09400) directly to ODJFS to initiate, terminate or adjust vendor payment on a specific resident as required.
- (10) Permit access to facility and records for inspection by ODJFS, ODH, CDJFS, representatives of the office of the state long-term care ombudsman, and any other state or local government entity having authority to inspect, to the extent of that entity's authority.
- (11) In the case of a change of provider agreement as defined in rules 5101:3-3-51.6 and 5101:3-3-84.5 of the Administrative Code, or dissolution of a business, follow the procedures in paragraphs (B)(11)(a) to (B)(11)(c) of this rule.
- (a) The exiting provider must provide a written notice to ODJFS, as provided in rules 5101:3-3-51.6 and 5101:3-3-84.5 of the Administrative Code, at least forty-five days prior to the effective date of any contract of sale or new lease agreement for the NF or ICF-MR.
 - (b) The provider must submit documentation of any transaction (i.e., sales agreement, contract or lease) as requested by ODJFS to determine whether a change of provider has occurred as specified in rules 5101:3-3-51.6 and 5101:3-3-84.5 of the Administrative Code.
 - (c) The entering operator shall submit an application for participation in the medicaid program and a written statement of intent to abide by ODJFS rules, the provisions of the new provider agreement; and any existing statement of deficiencies and plan of correction (HCFA 2567) submitted by the previous provider.

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- (12) Assure the security of all personal funds of residents in accordance with rules 5101:3-3-60 and 5101:3-3-93 of the Administrative Code.
- (13) Comply with Title VI and Title VII of the Civil Rights Act of 1964 (as amended through April 15, 2003) and Public Law 101-336 (the Americans with Disabilities Act of 1990, as amended through April 15, 2003), and shall not discriminate against any resident on the basis of race, color, age, sex, creed, national origin, or disability.
- (14) Provide to ODJFS, through the court of jurisdiction, notice of any action brought by the provider in accordance with Title 11 of the United States Code (bankruptcy, as amended through April 15, 2003). Notice shall be mailed to: "Office of Legal Services, Ohio Department of Job and Family Services, 30 East Broad Street-31st. Floor, Columbus, Ohio 43215-3414."
- (C) A provider of a NF shall:
- (1) Provide a statement to the individual explaining the individual's obligation to reimburse the cost of care provided during the application process, if it is not covered by medicaid.
- (2) Comply with the requirements in paragraph (F) of rule 5101:3-3-04.1 of the Administrative Code and repay ODJFS the federal share of payments under the circumstances required by sections 5111.45 and 5111.58 of the Revised Code.
- (3) During a closure or voluntary withdrawal from the medicaid program provide ODJFS, the resident or guardian, and the residents' sponsors a written notice of at least ninety days prior to the closure or voluntary withdrawal. A NF that does not issue the proper notice is subject to the penalties specified in rule 5101:3-3-51.6 of the Administrative Code.
- (D) A provider of an ICF-MR shall:
- (1) During a "closure" or "voluntary withdrawal" from the medicaid program provide ODJFS; the resident or guardian, and the residents' sponsors; a written notice at least ninety days prior to the closure" or "voluntary withdrawal". A ICF-MR that does not issue the proper notice is subject to the penalties specified in rule 5101:3-3-84.5 of the Administrative Code.
- (E) A provider of a NF or ICF-MR shall not:

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- (1) Charge fees for the application process of a medicaid individual or applicant.
 - (2) Charge a medicaid individual an admission fee.
 - (3) Charge a medicaid individual an advance deposit.
 - (4) Require a third party to accept personal responsibility for paying the facility charges out of his or her own funds. However, the facility may require a representative who has legal access to a individual's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the individual's income or resources if the individual's medicaid application is denied and if the individual's cost of care is not being paid by medicare or another third-party payor. A third-party guarantee is not the same as a third-party payor (i.e, an insurance company), and this provision does not preclude the facility from obtaining information about medicare and medicaid eligibility or the availability of private insurance. The prohibition against third-party guarantees applies to all individuals and prospective individuals in all certified NFs or ICFs-MR regardless of payment source. Notwithstanding the above, this provision does not prohibit a third party from voluntarily making payment on behalf of an individual.
- (F) ODJFS shall:
- (1) Execute a provider agreement in accordance with the certification provisions set forth by the secretary of health and human services and ODH.
 - (2) In the case of a change of operator, issue a new provider agreement to the entering operator contingent upon the entering operator's compliance with paragraph (B)(11)(c) of this rule.
 - (3) Provide copies of ODJFS rules governing the facility's participation as a provider in the medical assistance program. Whenever ODJFS files a proposed rule; or proposed rule in revised form under division (D) of section 111.15, or division (B) of section 119.03 of the Revised Code; the department shall provide the facility with one copy of such rule. In the case of a rescission or proposed rescission of a rule, ODJFS may provide the rule number and title instead of the rules rescinded or proposed to be rescinded.
 - (4) Make payments in accordance with Chapter 5111. of the Revised Code and Chapter 5101:3-3 of the Administrative Code to the NF or ICF-MR for services to individuals eligible and approved for vendor payment under the

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